## NORTH CAROLINA DIVISION OF MEDICAL ASSISTANCE 2006 MENTAL HEALTH RESIDENTIAL TREATMENT COST REPORT

## **SCHEDULE OF RELATED PARTY TRANSACTIONS**

**SCHEDULE D** 

Agency Name:

Tax ID:

						Number of
Description of Line Item	Line	Program/Cost			Expense	Paid Hours
(Expense/Cost)	#	Center/Column Name	Name of Related Party	Relationship	Amount	(If Applicable)
	1			1	1	